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3 July 2010

Under scrutiny

What error prosecution guidance really means for you page 8

CPD ZONE

AN ANNOUNCEMENT FROM ALLEN & HANBURYS

In January 2009 Allen & Hanburys launched Avamys®▼ (fluticasone furoate), an intra-nasal steroid (INS) for treatment of the symptoms of allergic rhinitis.[1] Avamys (fluticasone furoate) is a different chemical entity to Flixonase® (fluticasone propionate) and is therefore a distinct drug molecule and not a salt or a prodrug of fluticasone propionate.[2]

A survey taken in May 2009, amongst 128 pharmacists showed that:[3]

- 31% were unaware of this INS (Avamys, fluticasone furoate).
- 63% were not aware of the differences between fluticasone furoate and fluticasone propionate.

Allen & Hanburys would like to highlight the important key differences that will support you in dispensing the right medicine.

	fluticasone furoate[1,4]	fluticasone propionate[4,5]
Dose per spray	27.5mcg	50mcg
Sprays per pack	120	150
Licence Age	6 years and older	4 years and older
Cost (on prescription)	£6.44	£11.01

In a single dose study comparing Avamys to fluticasone propionate nasal spray, patients preferred Avamys over fluticasone propionate based on sensory attributes.[6] Avamys provides relief from both nasal and ocular symptoms in an advanced device.[7-10] Avamys is available to purchase from AAH and Alliance Healthcare.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing)

Avamys® ▼ Nasal Spray Suspension
(fluticasone furoate 27.5 micrograms/metered spray)
Uses: Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over. **Dosage and Administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). Reduce to lowest dose at which effective control of symptoms is maintained. *Children aged 6 to 11 years:* One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 microgram daily dose once control is achieved. **Contraindication:** Hypersensitivity to active substance or excipients. **Side Effects:** Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. *Very common:* epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 6 weeks). Common: nasal ulceration. *Rare:* hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria. **Precautions:** Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. Consider referring to a paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma and/or cataracts. **Pregnancy and Lactation:** No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the foetus or child. **Drug interactions:** Caution is recommended when co-administering with inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and ritonavir. **Presentation and Basic NHS cost:** Avamys Nasal Spray Suspension: 120 sprays: £6.44 **Marketing Authorisation Number:** EU/1/07/434/003. **Legal category:** POM. **PL holder:** Glaxo Group Ltd, Greenford, Middlesex, UB6 0NN, United Kingdom. **Last date of revision:** January 2010.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

Avamys is a registered trademark of the GlaxoSmithKline group of companies.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing.)

Flixonase® Aqueous Nasal Spray
(fluticasone propionate 50 micrograms/metered spray)
Uses: Prophylaxis and treatment of seasonal allergic and perennial rhinitis in adults and children aged 4 years and over. **Dosage and administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily in the morning. Once symptoms controlled, use mainlenance dose of one spray per nostril once daily. Two sprays per nostril twice daily may be required. Maximum daily dose four sprays per nostril. *Children aged 4 to 11 years:* One spray per nostril once daily in the morning. One spray per nostril twice daily may be required. Maximum daily dose two sprays per nostril. For full therapeutic benefit regular usage is essential. The minimum dose should be used at which effective control of symptoms is maintained. **Contra-indication:** Hypersensitivity to any of its ingredients. **Precautions:** Local infections should be appropriately treated. Caution when transferring patients from systemic steroids. Systemic effects of nasal corticosteroids may occur at high doses for prolonged periods. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. In addition, consider referring patients to a paediatric specialist. Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Avoid concomitant administration of inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole, and ritonavir. **Pregnancy and lactation:** Clinical data is not available. Balance risks against benefits. **Side effects:** Very common: Epistaxis. Common: Headache, unpleasant taste, unpleasant smell, nasal dryness, nasal irritation, throat dryness, throat irritation. Very rare: Cutaneous hypersensitivity reactions, angioedema, bronchospasm, anaphylactic reactions, glaucoma, raised intraocular pressure, cataract, nasal septal perforation. **Presentation and Basic NHS cost:** *Flixonase Aqueous Nasal Spray:* 150 metered sprays - £11.01. **Market Authorisation Number:** PL 10949/0036. **Market Authorisation Holder:** Glaxo Wellcome UK Limited trading as Allen & Hanburys, Stockley Park West, Middlesex, UB11 1BT. **Legal category:** POM. **Date of preparation:** January 2010.

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Flixonase is a registered trademark of the GlaxoSmithKline group of companies.

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For more information on Avamys visit **www.eyesandnoses.co.uk**

ALLEN & HANBURYS
The specialist respiratory division of GlaxoSmithKline

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> JUST WHEN CPS ERROR GUIDANCE LOOKED TO HAVE LEFT US BROKEN HEARTED, ALONG COMES THE MHRA, WHISPERING SWEET NOTHINGS ANEW

A deal to decriminalise dispensing errors has been on and off more often than teenage sweethearts. And just when CPS error guidance looked to have left us all broken hearted, along comes the MHRA this week whispering sweet nothings anew.

The UK drugs watchdog reveals that changes to the Medicines Act could be fast-tracked to remove the threat of criminal prosecutions (p4). A review is underway as an unexpected plan B for achieving decriminalisation takes shape.

But for many pharmacists the bunting will remain firmly packed in the box for now. The MHRA pledge, while an encouraging and unexpected bonus, has hurdles to clear. One will involve convincing the government of the case for bringing forward reforms to individual areas of the Medicines Act when the entire Act will be reviewed in two years anyway.

A second hurdle will involve pulling off a decisive lobbying campaign to secure support for legislative change from across the political parties. Pharmacy has got the backing for decriminalisation from Conservative, Liberal Democrat and Labour frontbench MPs. Earning the support of each party's rank and file will be a bigger test.

Even with this support, any law change is unlikely to arrive quickly – a prerequisite of any protection deal. Parliamentary machinery is hardly famed for being fleet of foot, just look at the delays the launch of the General Pharmaceutical Council encountered at Westminster.

Yet, for the romantics out there, you can compose a compelling counter argument to dispel these doubts. The MHRA – an organisation that regulates medicine safety on behalf of the public – is firmly behind the decriminalisation of one-off dispensing errors. That's a powerful signal for pharmacy. Only time will tell whether the association has enough clout to pull off effective dispensing error protection.

Until then, hopes rest with CPS error protection guidance. The initial reaction to the guidance last week was one of disappointment. Closer scrutiny by C+D has only reinforced that verdict (p8). The guidance, like England's World Cup campaign, promised so much in the build up yet delivered only disappointment.

Your Shout

You could be forgiven for developing a laissez-faire outlook in a sector that has undergone frenetic change in recent years. But you do have the power to push back. With a little help from C+D, Suffolk & Great Yarmouth LPC did just that this week, putting the government's pharmacy tsar on the spot with its five most pressing concerns (p10). Mr Mason's answers give an interesting insight into the future landscape for pharmacy in the NHS. C+D is keen to champion more of your concerns to key decision makers. Email any questions that you'd like to see answered to max.gosney@ubm.com for the chance to appear in our new Your Shout column.

Max Gosney, News Editor

Error protection deal hopes revived as MHRA reveals plan B

EXCLUSIVE Fast-track law changes under discussion after CPS guidance falls short

Chris Chapman
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A fast-track change in the law to protect pharmacists from prosecution for single dispensing errors just needs government approval, the MHRA has said.

The news comes only one week after a supposed error protection deal from the Crown Prosecution Service (CPS) failed to deliver.

Speaking exclusively to C+D, the MHRA said a reform of current rules was a priority, but could be delivered earlier than expected if agreed by politicians.

"We will look at any possibilities that could result in effective and safe implementation in advance of the Medicines Act review," an MHRA spokesman said. "If the change was to happen in advance of the review, it would be a legislative change which would require cross-government and parliamentary agreement."

The MHRA was currently working to reform the Medicines Act as a priority, a spokesman said, adding that last week's guidance from the CPS was "an interim measure".

The drugs watchdog would also talk "very shortly" with prosecutors in Scotland and Northern Ireland to arrange similar measures in devolved countries, the MHRA spokesman added.

Last week pharmacy minister Earl Howe reaffirmed his commitment to the decriminalisation of single dispensing errors, stating that he had asked chief pharmaceutical officer Keith Ridge "to work with the MHRA to explore the options as a matter of priority".

The Crown Office & Procurator Fiscal Service, responsible for prosecutions in Scotland, said it had not yet been approached by the MHRA about the Medicines Act.

Does the CPS guidance make any difference?

See news analysis p8

On the cards: MHRA pledge will resonate with thousands of pharmacists who have called on the government to decriminalise one-off dispensing errors

PDA warns rules could put RPs in the dispensing error firing line

Responsible Pharmacists (RPs) may find themselves the "unrealistic focus" for prosecutions under the Medicines Act in the event of a dispensing error, the PDA has warned.

The warning comes following further analysis of guidance on the prosecution of dispensing errors, issued last week by the Crown Prosecution Service (CPS).

Mark Koziol: the regulations have moved liability away from employers

Speaking exclusively to C+D, PDA chairman Mark Koziol said the guidance had placed too much emphasis on the RP rules, introduced in October 2009, when considering possible defences against a breach of the Medicines Act.

"There is an unrealistic focus on RP, giving the impression to prosecutors that RPs secure the safe and efficient running of pharmacies," Mr Koziol said.

He added: "The regulations in place have moved liability away from employers, because the impression given to the CPS is that the RP is setting the standards – that's a façade."

The guidance to prosecutors specifically cites the RP regulations as being "of assistance to prosecutors when considering the extent to which a defence of due diligence might apply in an individual case".

The RP regulations could also create a "perverse incentive" where a pharmacist could frame SOPs in such a way as to make technicians responsible for dispensing errors, Mr Koziol said. He added: "Where is the public interest being served by creating this incentive?"

The PDA was currently involved with several dismissals and disciplinary proceedings between employers and pharmacists over the RP regulations, in which pharmacists refused to assume the RP mantle after being dissatisfied with working conditions, Mr Koziol added. **CC**

Full Lee case verdict online

The judgment on the Elizabeth Lee case has been made public, following the quashing of her conviction for a dispensing error at the Court of Appeal last month.

The document weighs up the arguments raised by prosecutors and defence during Mrs Lee's appeal, and reveals the judges' verdict on what the Medicines Act means for pharmacists.

The three appeal judges condemn Mrs Lee's three-month suspended sentence as "manifestly excessive". "As all accept, the error did not, either as a matter of law or fact, cause [the patient's] death," the judges rule. **CC**

See the full judgment in the Elizabeth Lee case following the quashing of her conviction

www.chemistanddruggist.co.uk

Appeal bid turns tables on dispensing doctor

Go-ahead granted for pharmacy licence due to greater accessibility

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The decision to reject an application for a pharmacy in an area with a dispensing GP has been overturned.

The National Appeal Panel upheld the appeal by the TLC Pharmacy Group for a pharmacy licence in Tarves, Aberdeenshire after it was declined by the local NHS board earlier this year.

Superintendent pharmacist James Semple said he was pleased by the decision to grant the application.

The reversal comes after a consultation by the Scottish Government on measures to strengthen the appeals process for community pharmacy contract applications.

The RPSGB voiced concerns last month that the consultation into control of entry was triggered by unhelpful dispensing GP campaigns against pharmacy bids.

The National Appeal Panel said it recognised a community pharmacy would be more accessible than the GP surgery, which is only open 24 hours a week.

Mr Semple said: "We need to make it clear to GPs that they won't close if they have to stop dispensing.

"GPs should put the interests of patients over the bit of income they have lost and pharmacists need to show their added value."

Mr Semple added: "There really is a war going on up here and we have to fight."

Haddo Medical Group GP Fiona Munroe said the surgery was concerned about implications a pharmacy may have for their three sites. Dr Munroe said: "We were invited to community council meetings to discuss implications about the differences in dispensing services offered by pharmacists and GPs."

The local community council opposed the plans in a letter to NHS Grampian, citing adequate pharmacy provision in the area as a reason for its opposition.

An NHS Grampian spokesman said: "NHS Grampian, in its original consideration of the application, took the view that adequate pharmaceutical services were currently provided for the population of Tarves.

"However we note the National Appeal Panel has now approved the application from Mr Semple."

How FOI helped secure succ

Pharmacists are using the Freedom of Information Act (FOI) to identify areas with dispensing GPs that could be suitable for pharmacy openings.

James Semple (right) of TLC Pharmacy said he submitted an FOI request to NHS Grampian to identify high earning dispensing doctors in the area.

He found the Haddo Medical Group in Tarves earned £755,000 in a year from dispensing payments and used the information to support his bid.

He said: "There has been a big change in the past two years. The FOI Act has allowed pharmacists to be able to tell where dispensing doctors are dispensing more than they should."

Mr Semple added: "Where their turnover is in excess of the amount required to run a pharmacy, then that means pharmacies can put in applications."

Label homeopathic remedies 'placebos', say GPs

Pharmacists should label homeopathic remedies placebos, doctors have said.

The motion carried at the annual representative meeting of the British Medical Association (BMA) also called for an end to NHS funding for homeopathic medicines and to homeopathic placements for trainee doctors.

Speaking against the motion, representative Mary Church said that pharmacies would continue to sell the remedies as long as patients wanted them.

Dr Church said: "In large pharmacy chains homeopathic remedies are a drop in the ocean of a whole host of dubious medicines on offer."

Following the debate, BMA chairman of the council Hamish Meldrum said the BMA had received many letters accusing it of acting outside its remit by debating homeopathy.

Dr Meldrum added: "We must be conscious of how we say things; we can not be gratuitously offensive.

"Many people suggest we are threatening their livelihood and that debating this issue is a direct threat to them." **HF**

Steve Churton re-elected

Steve Churton has been re-elected RPSGB president for a third term. Nick Barber was elected vice-president. Accepting his re-election, Mr Churton highlighted the achievements of the RPSGB and re-affirmed his vision for the future professional leadership body.

Earl Howe makes debut

New pharmacy minister Earl Howe will present the government's perspective on the profession at the all-party pharmacy group's summer reception later this month, the group's first meeting since formation of the new parliament.

Alliance flu PGD

Alliance Healthcare is offering pharmacists a seasonal flu vaccination training and private patient group direction (PGD) package. The initiative offers clinical training, support in administering and marketing the service, and a pharmacist hotline.

Inequality role highlighted

The NPA highlighted the role of community pharmacy in tackling healthcare inequality at a conference last week. Speaking to NHS managers and local authority officials, the NPA said readily accessible community pharmacy provides a platform for lifestyle interventions, which can support health improvement.

Diabetes Awareness Week

Community pharmacists across the UK took to the streets during Diabetes Awareness Week last week to promote pharmacy screening services. Diabetes is estimated to be undiagnosed in more than half a million people in the UK.

Deaf awareness plea

The charity RNID has called on pharmacies to be more deaf aware, in a move it says could increase custom for pharmacy businesses. The call coincides with Deaf Awareness Week this week.

More on all these stories at
www.chemistanddruggist.co.uk

Dispensary talk

CPS error guidelines: hit, miss or maybe?

"I have to say I found the guidelines very disappointing. Making a mistake is still a criminal offence, but then what happens if a GP makes a wrong diagnosis? It's not very fair is it?"
Perry Melnick, Manor Pharmacy, Letchworth, Hertfordshire

"I don't think this is much of a step forward, it is a step sideways. We are still pretty much in the same place as dispensing errors can still be classed as a criminal offence."
Waqas Ahmed, Neils Pharmacy, Prescot, Merseyside

Web verdict

Hit 0%
Miss 83%
Maybe 17%

Armchair view: Pharmacists have offered a damning verdict on the CPS error guidelines released last week, as no respondent polled thought it would make criminal error prosecutions less likely and over 80 per cent said it was a big disappointment.
Next week's question: Will you accept the swine flu jab? Vote at **www.chemistanddruggist.co.uk**

Swine flu jab offered to pharmacists this winter

Sector finally recognised as 'frontline health staff' after snub in 2009

Gavin Atkin
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Community pharmacists have been included in this year's list of healthcare professionals to be offered swine flu vaccinations.

The news came in a letter issued by the interim chief medical officer Sally Davies. It comes one year after pharmacists were excluded from the priority list of health workers qualifying for the jab.

Professor Davies' letter argues that immunisation may reduce transmission of infection to vulnerable patient groups, and reminds NHS bodies of their responsibility to ensure healthcare workers are free from and protected against communicable infections.

Protection against the H1N1 swine flu strain will be offered as part of a trivalent seasonal influenza vaccine available from September.

NHS Trusts have been charged with ensuring health workers take up the immunisation jab.

Professor Davies said: "Trusts [and] employers will wish to ensure that health and social care staff directly involved in delivering care are encouraged to be immunised and that processes are in place."

Official figures showed over 40 per cent of qualifying NHS staff took the swine flu vaccine last year.

Professor Davies also warns of increased public demand for immunisations and the likelihood of increased media interest in vaccination during the 2010-11 flu season.

In another change, the new guidelines also include all pregnant women for the first time, rather than those in vulnerable groups. In the past expectant mothers were only offered vaccination if they belonged to a vulnerable group, but the new guidance reveals strong evidence that all pregnant women are at increased risk of complications from H1N1 swine influenza virus.

Pregnant women who have not received a dose of H1N1 swine flu vaccine should therefore be offered the trivalent seasonal vaccine when it becomes available.

A revised chapter on influenza for vaccine guide The Green Book is expected online by the end of July.

How media skills could boost your career
See Careers: page 24

Clinical debate

C+D's Chris Chapman looks at the evidence behind the headlines

Sativex: no cannabis shake-up

Few social issues are so divisive as the potential legalisation of cannabis. Last week's licensing of cannabis-based Sativex is likely only to add fuel to the fire, and pharmacists will face a grilling from customers asking why cannabis remains illegal.

But while all pharmacists know the health risks associated with cannabis, such as increased risk of some cancers and psychotic illness, what are the facts on Sativex?

Sativex is an oromucosal spray for the treatment of multiple sclerosis (MS) symptoms. It's actually been available unlicensed in the UK for years, under a Home Office open general licence – the change is that it's now licensed to improve symptoms related to muscle stiffness in MS.

The spray is started by a specialist on a four-week trial and is only continued if the patient shows significant improvement (it works in about 50 per cent of patients). Very common side effects include dizziness and fatigue, with common side effects including anorexia, depression, amnesia, blurred vision and vomiting.

Is there a risk of abuse? Yes, but it's limited. The MHRA report includes a study of 30 patients with a history of recreational cannabis use. It found eight sprays of Sativex has modest potential for abuse, and 16 substantial potential, when administered as a single dose. But the MHRA report advises that, given the indication and patient population, abuse is "not... of great concern".

So when it comes to Sativex as an argument for cannabis legalisation, let's not get ahead of ourselves. We don't advise a dinner of foxgloves and deadly nightshade because we happen to use digoxin and atropine for certain conditions, and opium dens haven't popped up on every corner just because codeine is available over the counter.

As with all medicines, it's about adopting a sensible approach to a potentially harmful substance. Cannabis is a class B drug: illegal to use, possess or sell. The health risks are well known. Sativex also has risks, but the benefits have only been found to outweigh them in a small group of patients.

Sativex is a treatment, not a political tool: it's not time to change advice to patients asking about cannabis just yet.

To discuss this subject in private with your pharmacy colleagues, join the debate in C+D's LinkedIn group at www.linkedin.com – search for Chemist and Druggist.

Chat with Chris on Twitter: www.twitter.com/CandDChris

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The NUROFEN Academy of Excellence

Error guidance under scrutiny

Following last week's CPS guidance on prosecutions under the Medicines Act, **Chris Chapman** takes a closer look at what the document means for the sector

There's no escaping it – last week's guidance on dispensing error prosecutions by the Crown Prosecution Service (CPS) was a damp squib. With a sickening inevitability, usually only reserved for dreams of English football glory, pharmacists' hopes were dashed as the guidance failed to deliver its promised protection.

"The effect is," concludes PDA chairman Mark Koziol, "that there is nothing contained in this guidance to guarantee that another Elizabeth Lee situation does not arise again."

So how ineffective is the guidance that was meant to put a halt to the criminal prosecution of single dispensing errors, as befell Ms Lee in April 2009?

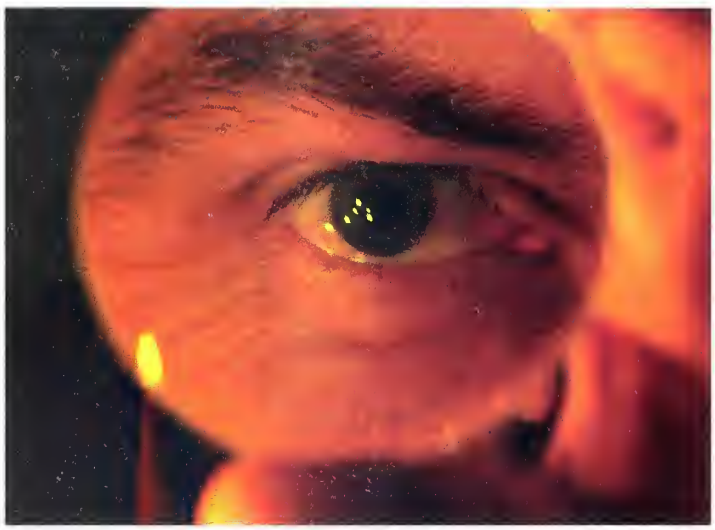
Despite being a general reiteration of the CPS's position, there is a slither of hope in the document, says Charles Russell solicitor David Reissner. Although Mr Reissner says there is "a lot of self-justification" in the guidance, it does set out the Full Code Test, a series of rules that prosecutors must follow (see box).

"You could read into the CPS statement an implication that prosecutors have failed to apply the test correctly, because you could take the view that if the CPS considered Mrs Lee's prosecution was justified, they wouldn't have needed to issue guidance," Mr Reissner says.

Mr Koziol also believes the guidance has a silver lining tucked away within its small print. "While it's not what we anticipated or were led to believe, it has made some incremental progress," he says. "If you look purely at the guidance it doesn't lead to much, but when combined with the guidance to prosecutors in February 2010, it does take a leap forward."

Mr Koziol is referencing the revision of the Code for Crown Prosecutors in February 2010, which included one key addition that impacts on pharmacists: "A prosecution is less likely to be required if… the suspect has been subject to any appropriate regulatory proceedings."

This alteration combines with the final point of the new guidance: "Has regulatory or remedial action been taken in respect of the pharmacist, pharmacy technician or any other person, or is it likely to be taken?"



Positive commitments may be hidden in the guidance's small print

Combined, the two points make it less likely for a pharmacist to be prosecuted for a dispensing error.

In the future, if a pharmacist is facing disciplinary action from the General Pharmaceutical Council over an error they are less likely to face criminal proceedings. But despite this positive commitment, there are other areas of the guidance that are more ambiguous.

Former RPSGB chief executive Jeremy Holmes says: "We are pressing for more clarity on the bullet points. But [the guidance] is helpful for the profession to show what CPS staff consider."

The guidance may even trigger increased involvement with the pharmacy regulator in prosecutions, as many of the points in the Full Code Test require expert knowledge.

It's surely another positive step that a prosecutor must consult pharmacy's regulatory body before deciding the seriousness of an error.

But these are small victories, nowhere near the desire of a halt on the prosecution of single dispensing errors until the Medicines Act can be reviewed. And ultimately one question remains: what is the intention of the CPS?

"The real issue," says Mr Koziol, "is the extent to which the CPS will go to get their prosecution, and the extent to which healthcare is being practised in a hostile environment."

> **"There is nothing contained in this guidance to guarantee that another Elizabeth Lee situation does not arise again"**
>
> MARK KOZIOL
> PDA CHAIRMAN

If CPS prosecutors follow the guidance and give significant weight to the actions of the regulator, pharmacists may have the protection they deserve. But if the CPS wants to prosecute, the guidance's protection is as thin as the paper it is printed on.

In 2007, Elizabeth Lee was a pharmacist. After one error – which did not contribute to the death of a patient – she was branded a criminal. Today, despite her successful appeal against the conviction, Elizabeth Lee works as a church cleaner, unwilling to return to practice. Her annual wage is less than she could have made in a month locuming.

This remains a fate that could still befall many pharmacists in the UK.

Prosecutors test for prosecutions

The points prosecutors must consider before prosecuting under the Medicines Act are:

- The culpability of those involved in the dispensing error; for example, was it simply an error or is there evidence of recklessness or intent?
- The seriousness of the dispensing error; for example, were the drugs particularly dangerous or poisonous in themselves, requiring very careful handling and additional checks to be in place; or was the dosage dispensed substantially greater than that prescribed or substantially beyond the usual treatment range?
- The consequences of the dispensing error; for example, did it lead to death or moderate or severe harm, or did it have the potential to do so (without, for example, the intervention of another person)?
- The actions of the pharmacist, pharmacy technician or any other person following the incident; did he or she report the incident and co-operate with the investigation or was there a failure to record or report the error, or evidence that it was concealed?
- Is there evidence that the pharmacist, pharmacy technician or any other person has made other dispensing errors?
- Has regulatory or remedial action been taken in respect of the pharmacist, pharmacy technician or any other person, or is it likely to be taken?

Source: Crown Prosecution Service

Does the error guidance go far enough?

Email chris.chapman@ubm.com or join the debate in C+D's LinkedIn group at www.linkedin.com – search for Chemist and Druggist

Are you ready for the hayfever season?

PRESCRIBING INFORMATION
Fexofenadine Hydrochloride
Telfast 120mg film-coated tablets
Presentations:
The tablets are film-coated peach coloured tablets containing 120 mg fexofenadine hydrochloride, equivalent to 112 mg of fexofenadine.
Indications:
For relief of symptoms associated with seasonal allergic rhinitis.
Dosage & Administration:
For the treatment of seasonal allergic rhinitis in adults and children aged 12 years and over, the recommended dose of fexofenadine hydrochloride is 120 mg once daily before a meal. The efficacy and safety of fexofenadine hydrochloride has not been established in children under 6 years of age.

Contra-indications:
Known hypersensitivity to any of the product's ingredients.
Precautions:
Studies in adults have shown that it is not necessary to adjust the dose of fexofenadine hydrochloride in the elderly or in renally or hepatically impaired patients. However, fexofenadine should be administered with care in these special groups.
Side effects (Please refer to the Summary of Product Characteristics for full side-effect details):
In controlled clinical trials the incidence of commonly reported adverse events observed with fexofenadine was similar to that observed with placebo. These adverse events were headache, drowsiness, nausea, dizziness, and sleep disorders or paroniria, such as nightmares. In rare cases rash, hypersensitivity reactions with manifestations such as angioedema, chest tightness, dyspnoea, and systemic anaphylaxis have also been reported
Pregnancy & Lactation:
Fexofenadine is not recommended in pregnancy or for mothers breast-feeding their babies, due to absence of experience in this group of patients.
Legal Category: POM
Marketing Authorisation Number: PL 04425/0157
NHS Price: Pack of 30 Tablets £6.23
Further information is available from Winthrop Pharmaceuticals, One Onslow Street, Guildford, Surrey, GU1 4YS.

Date of Revision of Prescribing Information: April 2009

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Adverse events should be reported and information about adverse event reporting can be found on www.yellowcard.gov.uk
Adverse events should also be reported to Winthrop Pharmaceutical UK Ltd as follows:- Email: uk-drugsafety@sanofi-aventis.com Tel. 01483 554242 Fax.:01483 554806

Tell us what's bothering you at C+D's Linkedin group
www.linkedin.com

Your Shout

Your Shout is a new series from C+D that aims to create a mouthpiece for grassroots pharmacy. We pledge to put your top concerns to the key government and industry decision makers. To take part email your questions to max.gosney@ubm.com or join C+D's Linkedin group at www.linkedin.com (search for Chemist and Druggist)

Tsar tackles your questions

From PCT cuts to getting picked for commissioning teams, Suffolk & Great Yarmouth LPC kicks off Your Shout by putting its top five concerns to the government's pharmacy tsar Jonathan Mason

1. Cracking the quality code

Suffolk & Great Yarmouth LPC: What should community pharmacy provide in terms of quality measures so PCTs commission us? A lot of what happens in our sector is not traditionally measured, so where do we start?

Jonathan Mason: The lack of data is an issue – the most important thing for community pharmacists and their teams to start doing is to start recording interventions. It is early days in the development of quality measures for pharmacy and community pharmacy in particular.

I don't want to be prescriptive, since I think that the profession needs to agree what metrics will demonstrate the quality of pharmaceutical services. However, I think it is important that we develop a range of indicators that measure the following:

- **Access** – do community pharmacies provide the range of services their patients need or want, and are those services available when patients need them? Are medicines available when patients need them – have pharmacists audited waiting times, owings etc?
- **Patient experience** – use the patient satisfaction survey to identify what needs to be improved; are patients provided with sufficient confidentiality during consultations? Have you asked patients whether or not your pharmacy offers sufficient privacy?
- **Safety** – are you recording and reporting errors (prescribing, dispensing etc)? Are you recording interventions, for example identification of contraindications, adverse effects, etc? Have you audited compliance with NPSA safety alerts?
- **Effectiveness/outcomes** – are you recording outcomes from MURs, for example if you have made recommendations to GPs have they been followed or acknowledged? Are you recording interventions for specific patient groups, for example advising pregnant women which drugs to avoid, or changes to regular medication? Are you recording interventions, such as advice for self-limiting illness?

2. Getting picked for commissioning teams

Suffolk & Great Yarmouth LPC: What will be done at a national and regional level to ensure that pharmacy is included and recognised within new primary care-led commissioning groups?

Jonathan Mason: For the moment, PCTs will continue to be responsible for pharmaceutical services contracts. At regional level, LPCs should work with PCTs, LMCs and PBC consortia to identify areas in which pharmacists and GPs can work together.

Pharmacy as a profession needs to identify clinical leaders, particularly in community pharmacy – the new world of clinical commissioning will require clinical leaders from all professions to work together to lead service development.

3. Name our no 1 priority

Suffolk & Great Yarmouth LPC: What areas do you think community pharmacy need to concentrate on now to show they can deliver – is it MURs?

Jonathan Mason: Yes, I think community pharmacists need to demonstrate the value of MURs – work with PCTs and GPs to identify groups of patients who will benefit most from MURs and focus on these patients, and record interventions. I think pharmacists also need to start recording interventions for self-limiting illness, emergency contraception etc, to demonstrate value with regard to reducing GP appointments, and visits to walk in centres and hospital A&E departments.

4. Protecting against PCT cuts

Suffolk & Great Yarmouth LPC: How will PCTs hit by cutbacks be encouraged and monitored to deliver sound and workable PNAs?

Jonathan Mason: PCTs have a statutory obligation to ensure that their PNAs meet the requirements of The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) (Amendment) Regulations 2010.

5. Selling our services to the public

Suffolk & Great Yarmouth LPC: What is being done at a national level to raise public awareness over the value and role of pharmacy in public health?

Jonathan Mason: In the current climate, I think this would be within the remit of the national pharmacy organisations.

How pharmacy will fare under the new government – watch Jonathan Mason give the inside brief

www.chemistanddruggist.co.uk/mason

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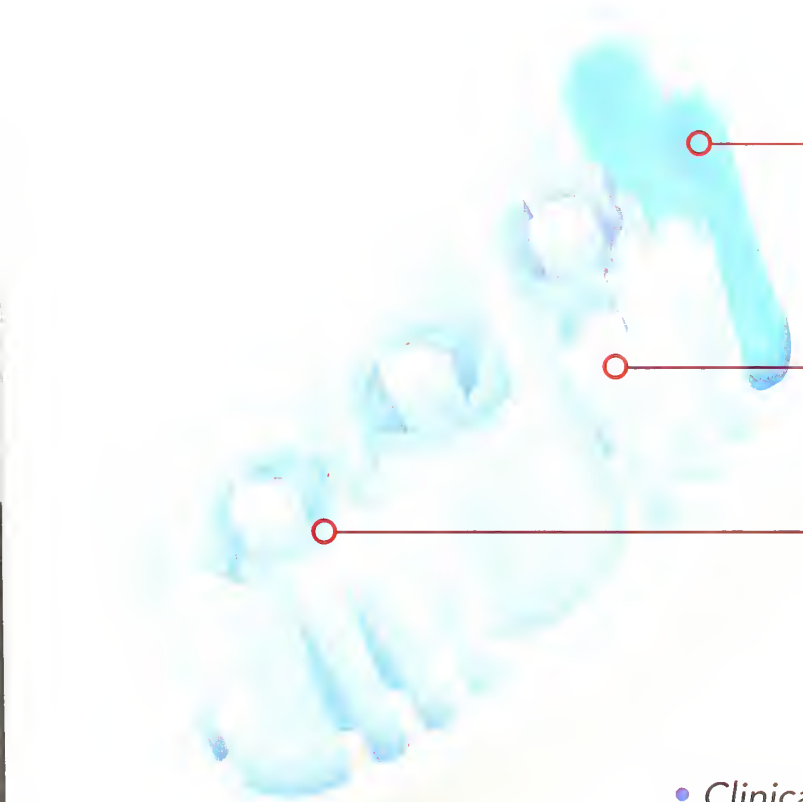

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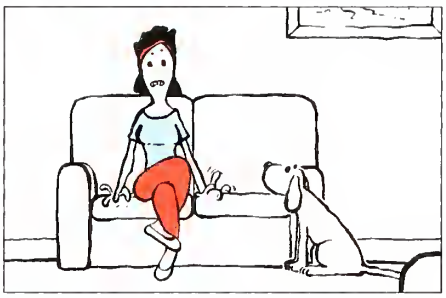
1 Nathoo S et al, (2006) New Jersey Dental School UMDNJ. Data on file, Colgate-Palmolive

www.colgatepharmacy.co.uk

Canesten invests in summer promotion

Canesten is set to be the focus of a television campaign this summer, Bayer Healthcare has announced.

The campaign is part of a £1.5 million investment in the brand by the manufacturer. Adverts will air on national television channels in July and August, to coincide with the higher incidence of thrush in the summer.



The advert encourages women to trade up and choose one of the combination products, says Bayer. Treatments featured in the advert are Canesten Duo, Canesten Cream Combi and Canesten Combi.

Prices: £12.99/1-10g (Canesten Duo); £11.93/10g (Canesten Combi); £11.93/5-10g (Canesten Cream Combi)
Pip codes: 302-0328; 304-7719; 328-2597
Ceuta Healthcare
Tel: 01202 780558

Market focus

- The thrush market is worth £31.8 million in pharmacy.
- Canesten has a 75 per cent share of the pharmacy thrush products market.

Source: Nielsen MAT, 52 weeks to April 17, 2010

More from your Mudd masks

Mudd facial masks are being repackaged, manufacturer Chattem has announced. Five- and 10-application resealable pouches are launching this month, alongside single use sachets.

This is a first for the facial mask category and offers better value for money, says the company.

The larger pack additions cover the most popular varieties in the range.

Prices: £0.99/single-use; £2.99/five-application; £4.99/10-application
Pip codes: See C+D Monthly Price List or www.cddata.co.uk
Miles Group
Tel: 01484 536344

Larger Movelat pack sizes offer further five days treatment

Genus Pharmaceuticals is launching 125g packs of prescribable osteoarthritis treatments Movelat Cream and Gel this month.

The product was previously available in 100g packs.

The packaging has also been updated to include the Movelat 'moving cogs' graphic, according to the company.

The larger pack offers value for money and provides an average of five extra days of treatment, Genus adds.

Movelat Cream and Gel are topical anti-inflammatories licensed for mild to moderate osteoarthritis and musculoskeletal pain.

Prices: From £7.19/125g (NHS)
Pip codes: Please see C+D Monthly Price List or www.cddata.co.uk
Genus Pharmaceuticals
Tel: 01635 568400
www.genuspharma.com

Seabond TV campaign puts dentures firmly in their place

Combe International has announced Seabond Denture Fixative Seals are set to be the focus of a television campaign this month.

The advert focuses on the "all-round fit you can really feel" strapline, which demonstrates how Seabond seals lock dentures firmly in place so they won't move about, according to the company.

The all-round fit claim has also been added as an update to the latest packs, the company says.

Advertising of Seabond has risen to £1 million as part of a £10m investment in Combe's key brands throughout this year.

Prices: £12.84/6 (trade)
Pip codes: 252-3470 Fresh Mint lower; 252-3488 Fresh Mint upper; 020-6466 Original lower; 020-6474 Original upper
Combe International
Tel: 0208 680 2711

Probiotec launches in Rowlands

Probiotec has teamed up with Rowlands Pharmacy for the UK launch of its BioRemedies vitamins and supplements range, which will be exclusive to the multiple for the next six months.

BioRemedies products contain full clinical doses of proven ingredients, says the Australian manufacturer. The range includes lactoferrin-containing Immune Life, which the company claims can boost natural defences and help people fight infections naturally.

"Rowlands Pharmacy is uniquely positioned in the UK market to provide advice and education around the BioRemedies range and to start spreading the message about preventative health," says Probiotec general manager Dusty Stringer.

Probiotec UK
Tel: 01244 357295

Check out what's on TV this week

www.chemistanddruggist.co.uk/prodnews

The Finance Zone

PART 6: Profit extraction. Richard Baker explains how to plan your strategy

When planning how to extract profits from your company as tax efficiently as possible, the best place to start is estimating what your profits are likely to be. This has been made difficult by category M in recent times, but a range of profits is fine as a starting point.

There is a number of methods of profit extraction, including:

- salary and bonuses
- dividends
- interest on shareholder loans
- personal pension contributions
- rents on shareholder properties.

In practice, any strategy is likely to involve a combination of these, depending on your circumstances.

Many of you will be taking a mixture of salary and dividends from your companies and in many situations this works, depending on the level of profits generated. Notwithstanding this, there are two main pitfalls:

- Dividend payments are restricted to the level of profits available within a company and this, in many cases, will not be known until the final accounts are drawn up.
- If you have 'sleeping partners' within the business (those who do not play an active role, for example if their input is capital only), you may not want them to benefit from a dividend that is effectively an element of your earnings.

For those generating profits of more than £300,000 (this figure could be less depending on how many companies are under your control) it may be beneficial to pay out a greater level of salaries. Again, this comes back to the first point of having a rough idea of profits. Future reductions in the main rate of corporation tax, announced in the Budget last week, will impact on this particular profit extraction strategy.

Richard Baker: last week's Budget could affect profit extraction strategies

With a 50 per cent rate of income tax now in force, it is worth revisiting your profit extraction strategy to ensure it is still beneficial. If your taxable income is greater than £100,000, such a review is essential.

Richard Baker is a partner at accountancy firm Horwath Clark Whitehill

Horwath Clark Whitehill

Key points

- To plan how to extract profit from your business, start by estimating what those profits will be.
- There are several methods of profit extraction and your strategy is likely to be a mixture of these.
- Now is a good time to revisit your profit extraction strategy to take into account the 50 per cent income tax rate and other changes that were announced in last week's Budget.

NEXT MONTH

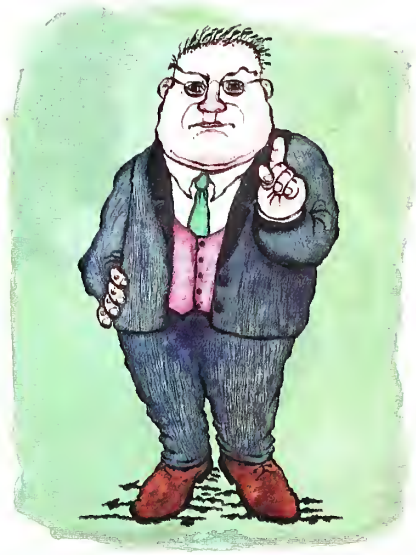
Budgeting for locums

Catch up with all the Finance Zone articles online at www.chemistanddruggist.co.uk/finance, which combine both the latest finance news and expert views to offer a quick guide to managing your money:

- Part 1: Financial advice to help realise market opportunities
- Part 2: Tax issues for pharmacy buyers and sellers
- Part 3: Inheritance tax
- Part 4: Business planning
- Part 5: Retirement planning

What do you think?
haveyoursay@chemistanddruggist.co.uk

In danger of losing the human touch



"HOW LONG BEFORE WE SEE A Wii FIT BOARD THAT SCANS AND CONDUCTS BLOOD TESTS, ONLY FOR A WiiGP TO APPEAR ON SCREEN?"

Video recorder, personal computer, mobile phone, Twitter, iPad – name every technology you find confusing, and that's how many decades since you left school. Maybe that's why my heart sank last week as I read about the latest automated dispenser (C+D, June 26, p4), which is yet another example of using a technological answer not because we need to, but because we can.

Ten years ago, robot dispensing machines first appeared in hospitals to a fanfare, promising efficiency, safety and reliability. A tour of our local robot revealed – to my great regret – nothing like C3PO from Star Wars, but a small glass-walled room with lots of shelves.

Clearly excited about the £1 million vending machine, the pharmacy manager explained the efficiency and accuracy. Considering the automated picking used by our wholesalers – and the missing or incorrect lines we receive – I questioned this error-free utopia. "Well, we still make labelling errors, of course," came the reply. "And then it can't cope with bulky or irregularly shaped stock. And a couple of times a day we have to go in to free a jammed box. We're sure to see the staff savings soon..." Thus clinical skills are replaced by those of a caretaker.

And so to reports that PharmaTrust hopes to bring its automated dispensing machine to the community. The company stressed the machine is not an attempt to replace pharmacists, but to allow us to concentrate on delivering patient services. At a cost of £50,000, that's only an extra 200 MURs a year for 10 years before turning a profit and by that time we'll have something else new – probably Star Trek replicators the size of a microwave. If that's not enough Brave New World for you, Bristol PCT has released an iPhone app to locate its NHS services. There's also a link to NHS Direct and, should you dial 999, podcasts guide your emergency treatment while waiting for the ambulance. How long before we see an updated Wii Fit board that conducts scans and blood tests, only for your virtual reality WiiGP to appear on screen with a reassuring diagnosis?

So, are you worried your next pharmacy technician – or even GP – will need batteries? I'm more concerned by the accompanying picture of the remote video link, resurrecting the image of remote supervision. Any pharmacy going for this is missing the point of personal contact – that is what healthcare is all about, played out not as a video game but in real life. It also contrasts with the hurried 10-minute surgery consultation, where everything from automated phones to out-of-hours co-ops seem designed to avoid patient contact.

So if we can be replaced by a dispensing machine, then we deserve to be – though I hear the local trust's hospital robot has been out of action, awaiting a spare part, for three weeks. As the philosopher Elbert Hubbard said: "One machine can do the work of 50 ordinary men. No machine can do the work of one extraordinary man."

Paying the price for free prescriptions

Since April 1, when Northern Ireland (NI) abolished prescription charges, there has been surprisingly little media attention.

Due to NI's dire financial situation generally, and the health cutbacks specifically, the move was ignored by the press. Early in the year it was felt by some in the know that the free prescription policy might be shelved, but perhaps with an eye on the general election, the minister felt the political risk of a volte-face on April Fool's day would be too great. In the end for his party, the Ulster Unionists, it hardly mattered; they now have no seats at Westminster.

Surprisingly, among pharmacists views on the abolition of the charge remain ambivalent. Some have even expressed disappointment with free prescriptions, which is surprising given the profession has politically opposed the existence of a prescription charge as a tax on the sick since its inception in the 1960s.

Health service funding in NI is in difficulties, with a shortage of some £113 million over the next few years and additional health cuts promised by the new Westminster government – perhaps an additional £10m in NI.

The drugs budget, soon to be handed from the NI health department, the DHSSPS, to the new health board, has been capped at £405m. When administered by DHSSPS, a cap did not exist; when the drug's budget was overspent DHSSPS made up the shortfall. Not any more. Given this, there is a fear on the board that the abolition of script charges could stimulate an increase in numbers, impacting on drug costs and making it difficult to stay within budget.

The board will be trying to save over £40m in drug costs in the current year just to stay in budget. Much effort will be made to increase the percentage of medicines prescribed and dispensed as generics and cutting drug waste. If our drugs cost per head of population was similar to England then there is at least £75m to be saved on the current bill. The DHSSPS and the board suggest they are keen to work collaboratively with community pharmacy in making these savings. But there seems little commitment to specific projects and perhaps this reflects current poor relations.

More worryingly, in the absence of a new pharmacy contract the NI minor ailments scheme is continuing on a temporary basis until July 31. This is unsatisfactory as a temporary scheme in an environment of cutbacks is highly vulnerable. Since the abolition of prescription charges access to the scheme is open to all; previously only those exempt from prescription charges could use it.

As pharmacists, we need to be responsible with the scheme and help the public be responsible with it, too. Do otherwise and encourage a free-for-all, and we might lose it.

Terry Maguire is a community pharmacist in Northern Ireland

"THERE IS A FEAR THE ABOLITION OF SCRIPT CHARGES COULD STIMULATE NUMBERS AND MAKE IT DIFFICULT TO STAY WITHIN BUDGET"

Update

Your weekly CPD revision guide

The diagnosis and risks of RA

The first of two articles on rheumatoid arthritis explains the condition is not just a disease of the joints but can lead to heart conditions, osteoporosis and infections

60-second summary

Do you know the defining signs of RA, and how the disease progresses? This CPD article should help you understand more about this destructive disease.

What causes RA?

The exact cause is unknown. Although not directly inherited, there is a clear genetic component. Mycoplasma infection, Epstein-Barr and rubella viruses have been implicated. Flu-like illness sometimes precedes RA onset, supporting the view that certain micro-organisms may activate irregularities in the immune system. As RA is three times more common in women but supressed during pregnancy, sex hormones may also play a role.

Which lifestyle factors, if any, have been linked with RA?

Smoking, red meat consumption and high coffee intake. Conversely, people with a high vitamin C and moderate alcohol intake appear to have reduced risk.

To get Update emailed to you each week, register for C+D's CPD newsletter at www.chemistanddruggist.co.uk/register

Helen Boreham MSci

Rheumatoid arthritis (RA) affects more than 400,000 people in the UK.[1] The incidence of new cases in adults is about 50 per 100,000 people each year, coupled with a prevalence of existing disease of between 0.5 and 1 per cent.[2] Overall, this makes RA the most common inflammatory arthropathy in the UK.

However, what the prevalence figures alone fail to convey is the huge morbidity burden imposed by this destructive, disabling disease. RA impacts not only on patients – causing pain, disability and early mortality – but also affects families, employers, the NHS and society as a whole. As a result, RA carries a high economic cost estimated at between £3.8 billion and £4.75bn per year.[1]

Signs and symptoms

The key symptoms of RA are joint pain, swelling and stiffness in the affected joint(s). This stiffness tends to be worse in the morning or after a period of rest. Other signs suggestive of RA include:

- simultaneous pain in three or more joints
- joint pain that persists throughout the night
- symmetrical joint pain, eg pain in the index finger of both left and right hand
- swelling of joints
- morning stiffness lasting longer than 30 minutes.

RA can also be associated with extra-articular signs and symptoms that develop outside the joints. These include:

- small painless lumps on the elbows and forearms (rheumatoid nodules)
- fatigue
- inflamed tendons
- flu-like symptoms – fever, sweats, muscle aches
- weight loss.

In rare and severe cases, RA inflammation can extend to the lungs, heart, blood vessels or eyes, leading to serious complications such as fibrosis or vasculitis.

RA usually starts gradually with mild, intermittent symptoms of joint pain, swelling and stiffness – often in the fingers, wrists or balls of the feet. Over time, these symptoms inevitably become more severe and more frequent as the underlying RA-driven inflammation takes hold. In around 20 per cent of cases the disease onset is rapid, with a sudden explosion of quickly-escalating joint pain, stiffness and loss of function.

Differential diagnosis

RA usually targets the small joints in the fingers, thumb, wrists, feet and ankles. The knees are also commonly involved, but less so the hips, shoulders, elbow and neck. However, a whole host of different conditions can cause joint symptoms reminiscent of RA, so differential diagnosis is a critical clinical challenge.

According to the gold-standard American College of Rheumatology (ACR) classification criteria, RA patients must display four of the following:[3]

- Morning stiffness lasting at least one hour
- Swelling in three or more joints
- Swelling in hand joints
- Symmetric joint swelling
- Erosions or decalcification on hand x-ray
- Rheumatoid nodules
- Abnormal serum rheumatoid factor.

These criteria offer a loose diagnostic touchstone only, as no test or symptom exists that can definitively distinguish RA from other types of arthritis. Two thirds of RA patients are positive for rheumatoid factor, but many patients will have sero-negative disease. A more specific test for RA, developed recently, is anti-CCP, which detects the presence of cyclic citrullinated peptide antibodies in the blood. High anti-CCP levels can help confirm a diagnosis of RA and may offer an insight into a patient's risk of joint damage. X-rays, MRI and ultrasound are other important diagnostic tools that can detect ongoing active synovitis and reveal any structural damage to the joints caused by RA.

In clinical practice, the final diagnosis of RA is based on careful consideration of all symptomatology, combined with blood test and imaging results.

Causes

The exact cause of RA is unknown but both genetic and environmental factors play a part. Although not a hereditary disease, RA has a clear genetic component. One particular genetic marker (the HLA-DR4/DR1 cluster) is present in up to 90 per cent of RA patients, but also found in over 40 per cent of the normal healthy population.[4]

Environmental factors that have been implicated in RA development include, among others, infectious agents such as mycoplasma organisms (bacteria that lack a cell wall and which are immune to some common antibiotics), and also Epstein-Barr virus and rubella viruses. It is thought that infection with these pathogens may somehow induce RA via activation of the immune system.

This theory is supported by the observation that flu-like illnesses are occasionally reported before

the onset of arthritis, and bacterial products – including bacterial DNA – are often found in the joints of rheumatoid patients. Moreover, RA can be induced in animal models using infectious bacteria or bacterial products.

Sex hormones may play a role, explaining the high number of female sufferers and the suppression of RA during pregnancy.

Whatever the trigger, the underlying immunological changes that mark the start of RA may be set in motion many years before symptoms appear. All the major elements of the immune system have a part to play in starting, propagating and maintaining the auto-immune joint attack. Key players include T- and B-cells, antigen-presenting cells and various cytokines.

Risk factors

Although not a directly inheritable disease, RA does appear to run in families and a family history of RA may convey a higher risk – however even the identical twin of an RA sufferer only has a one in five chance of developing the disease.

Women are three times more likely to develop RA than men, supporting the potential link to female hormones. Age is another significant risk factor as the disease most commonly manifests between 30 and 50 years of age.[5]

Increasing evidence is emerging to indicate that lifestyle factors may play a part in RA development. Smoking, consumption of red meat and high coffee intake have all been linked to a increased risk of RA.[6] Similarly, people with a high vitamin C intake and those who drink alcohol in moderation appear to be at lower risk.[6]

RA is found in all ethnic groups but prevalence is much higher in some races, eg Native Americans, while other groups are at lower risk, eg black people from the Caribbean region.

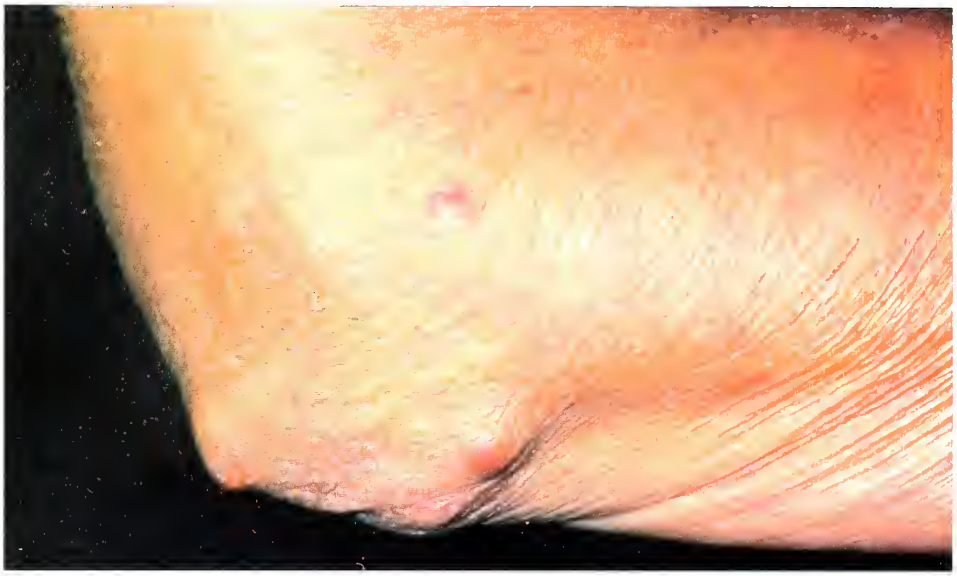
Pathophysiology

RA is an auto-immune disease in which aberrant immune and inflammatory reactions are launched within the body. What acts as the initial trigger is unknown, but the result is an abnormal immune response targeting joints lined with synovium (a specialised membrane responsible for keeping the joint lubricated and providing nutrition). Inflammation within the synovium results in a large increase in blood flow to the joint.

This gives joints a reddish hue and can make them feel warm. At the same time, proliferation of the synovial membrane and increasing levels of synovial fluid (the lubricating liquid produced by the synovium) causes joints to swell. The pain felt in rheumatoid joints arises from stretching of the pain receptors in the soft tissue around the joint and the surrounding bone. Inflammatory chemicals produced during the auto-immune reaction can also irritate nerve endings.

Inflammation in the joint doesn't just affect the synovium but can erode and wear down the cartilage. The bone underneath the joint may become thin and muscle around the joint will be lost rapidly. Inflammation can also damage the joint capsule and nearby ligaments, and tendons may become inflamed. Over time, the destruction of joints and tendons may lead to characteristic RA deformities which include:

- Ulnar deviation – a drift and bending of digits towards the little finger.
- Boutonniere – a finger deformity where the joint nearest the knuckle is permanently bent toward the palm while the furthest joint is bent back away.
- Swan neck deformities of the fingers.



Dr P Marazzi/ Science Photo Library

Small painless elbow nodules are one of the signs suggestive of rheumatoid arthritis

More than just joints

Although it is commonly thought of as a joint-specific condition, RA is in fact a systemic disease. Inflammatory mediators like TNF-alpha, which generate the characteristic pain and stiffness in the joints, also impose a body-wide inflammatory burden. This ongoing inflammation drives atherosclerosis, causing progressive artery thickening and reducing blood supply to vital organs. As a result, heart conditions such as ischemic heart disease and cardiac failure are more common in RA patients, and life expectancy may be reduced. Overall, the risk of cardiovascular death in RA patients is 60 per cent higher than in the general population.[4]

The risk of osteoporosis is also raised, resulting from a combination of reduced mobility, inflammation and steroid use. Similarly, immunosuppressant medication, combined with inherent immune system problems, can make RA patients more prone to infection.

Disease course

RA is characterised by fluctuating symptoms with no particular pattern. Patients commonly experience flare-ups where joint pain and inflammation intensifies, followed by periods where symptoms seem to settle.

The course of RA is both heterogeneous and variable, so outcomes for individual patients are almost impossible to predict. However, key factors associated with poor prognosis include:

- positive serum rheumatoid factor
- family history of RA
- male gender
- persistent synovitis
- early erosive disease,
- extra-articular signs of disease (such as rheumatoid nodules) and advanced age.

In all patients, the potential exists for widespread joint and soft tissue damage, coupled with an accessory inflammatory impact on most organ systems in the body. The degree of progressive damage that the joints undergo is related to both the intensity and duration of the inflammation. Joint damage itself can then lead to deformity, disability and handicap.

Broadly, the prognosis for RA patients is as follows:[6]

- One fifth will always have very mild RA.
- Three quarters will continue to follow a pattern of flare-ups interspersed with periods of little inflammation.
- Five per cent will develop severe disease, which progressively worsens and is associated with extensive disability.

Within two years of RA diagnosis, most patients experience moderate disability and a third of patients will be forced to stop work. After a decade of disease, 30 per cent of sufferers will be severely disabled.[1] Life expectancy in RA patients is reduced by around five to 10 years on average.[4]

References are available in the full version of this article at www.chemistanddruggist.co.uk/update

Helen Boreham is a freelance medical writer with an MSci in medicinal chemistry

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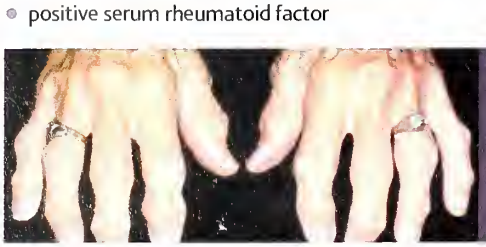

NEXT WEEK
Part 2 describes the management and drug treatment of RA

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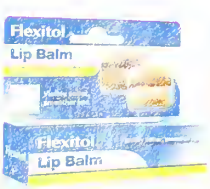

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Rheumatoid arthritis: part 1

Reflect

What are the extra-articular symptoms associated with rheumatoid arthritis (RA)? Which joints are commonly affected? Why are the risks of heart disease and osteoporosis increased in patients with RA?

Plan

This article discusses the signs, symptoms and diagnosis of RA. It also includes information about causes, risk factors, pathophisology, how the rest of the body is affected and disease progression.

Act

- Find out more information about RA, including how it damages the joints from the National Rheumatoid Arthritis Society (NRAS) website at http://tinyurl.com/rheumatoid1.
- Read more about RA on the Patient UK website at http://tinyurl.com/rheumatoid2, which includes information about systemic involvement and complications.
- Find out more about the causes and risk factors of rheumatoid arthritis from the NRAS website at http://tinyurl.com/rheumatoid3.

Evaluate

Are you now familiar with the symptoms of RA? Are you confident in your knowledge of the causes, risk factors and disease progression of the disease? Could you explain to a patient how the joint damage is caused?

5 minute test
What have you learned?

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Step 2

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Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

Practical Approach

How do you tackle persistent lateness?

A group of pharmacists are chatting over refreshments during an RPSGB local branch meeting.

One of them, who owns four shops, says: "I don't know if any of you can help me with a problem I've got with a young pharmacist I employ? He's excellent in every way - except that he's consistently about half an hour late for work in the morning. Of course, the branch just can't function until he turns up. We're losing business and it's upsetting the other staff."

"Can't you just sack him?" one pharmacist asks.

"I don't think it's as simple as that. Anyway, I'd really like to hold on to him if we can find a way round the problem."

"Have you spoken to him about it?" another colleague says.

"Of course. Apparently, he's a night owl and has terrible difficulty getting up in the morning – it's more or less pathological. He acknowledges it, and he says he's quite willing for me to dock his pay to compensate, but that's not the answer."

"How about putting him on a later shift?" a third pharmacist suggests.

"It's only a small branch, open from nine to six, and he's the only pharmacist. I've thought of swapping him with a pharmacist in my big branch that's open until 10 at night, but I don't want to unsettle my staff there."

"Then I can't see you having any alternative but to sack him in the end," says the pharmacist who made the first suggestion.

Questions

1. Why is sacking the pharmacist "not as simple as that"?
2. What is the correct procedure in these circumstances?

Answers

1. Sacking an employee for being late to work a few times would be legally considered a summary dismissal. Such a dismissal for anything but the most serious employment offences (eg violence or theft) is, under employment law, considered unfair. Under those circumstances, the employee could take the employer to an employment tribunal, and if the tribunal were to decide in the employee's favour the employer may be made to pay a substantial compensatory award.

2. Occasional lateness is considered to be minor misconduct, but if repeated after warnings it becomes grounds for dismissal. The employer should hold a disciplinary meeting, giving the employee a set time to improve. If there is still no improvement, he should issue a first written warning, outlining again the improvement expected and a timeframe. If there is still no change, a final written warning can be issued, again giving the opportunity to improve within a certain time, but warning that if there is no improvement dismissal will be considered. If the pharmacist continues to turn up late for work, he should be called to a meeting at which he is dismissed and given a letter explaining the reasons for dismissal and the procedure that has been followed. Notice or payment in lieu must be given.

Reference

Actavis Academy case studies, www.actavisacademy.co.uk

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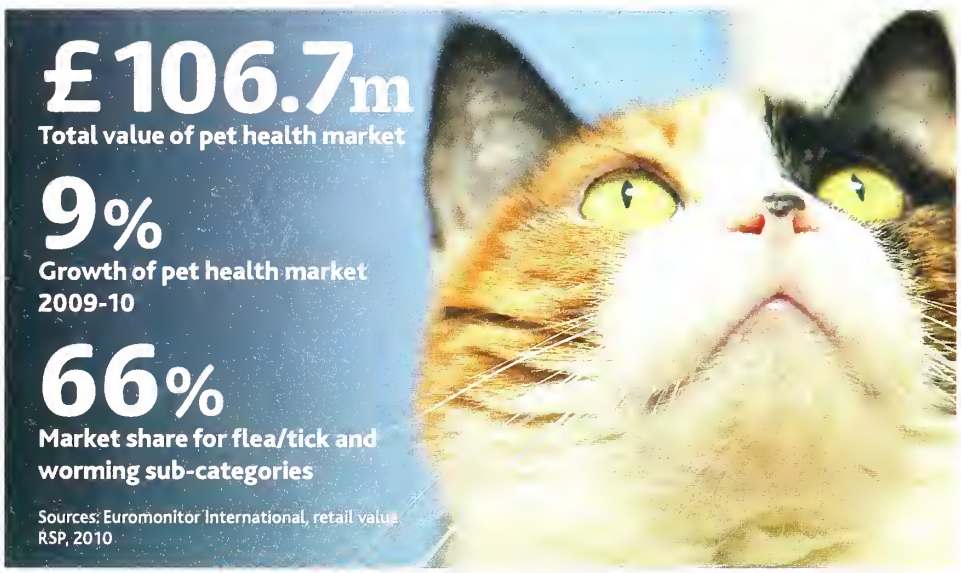
CATEGORY FOCUS

Pet health

The market is worth over £100 million, so stocking petcare products makes economic sense and could lead to add-on sales, finds **Emma Wilkinson**



Pet health is a relatively new aspect to the pharmacy business. Before 2005, when a range of veterinary medicines was reclassified, enabling sale through pharmacy, the local vet had cornered what is potentially a very lucrative market.

According to a 2008 report from the RPSGB English Pharmacy Board (EPB), the pet medicines category, led strongly by the Frontline and Drontal brands, is worth more than £100 million – a considerably larger market than that of many traditional OTC markets.

Reigning cats and dogs

When you bear in mind that more than half of households in the UK own at least one pet – a statistic that includes eight million cats and seven million dogs – yet many are not being properly wormed or regularly treated with flea control products, the potential for even further growth in sales is pretty staggering.

It is also worth considering that encouraging customers into the store for pet health products could easily lead to their custom for other aspects of their own and their family's health. The EPB report estimated that half a million pet owners visit their pharmacy every day, so this is a market that the community pharmacist would be foolish to discount.

Andrew Cairns, chair of the RPSGB Veterinary Pharmacists Group, wholeheartedly agrees that pet medicines is a great market to get involved in. "There are several reasons for doing it, some of them commercial – these are products which promise to be profitable and bring people into the pharmacy," he says.

"You can also make an excellent professional case for doing it. Going back to the fundamentals, we see more members of the public than any other health professionals and we are in a position to give proper health advice. For example, there are diseases which are transmittable from animals to humans and we are in the perfect position to advise and educate people on that."

Mr Cairns adds that although pharmacists may be reticent to take on responsibility for pet health due to lack of knowledge, there is a huge amount of training and information support available.

"The National Pharmacy Association does an information pack on basic information and getting information and advice from the manufacturers is very easy. For those who want to do it in more detail there is a distance learning module through the RPSGB, and you can get more information on that at www.vpep.net."

The EPB report estimated that in 2008 just 750 non-specialist pharmacies sold pet medicines and that the sector held less than a 5 per cent share of the market. But the pet health bandwagon is something that many multiples have now jumped on and there is a sense, says Mr Cairns, that the profession is becoming mobilised. For example, April saw Lloydspharmacy launch a dedicated pet healthcare website. "There is going to be a lot of momentum in this area over the next five years," Mr Cairns says.

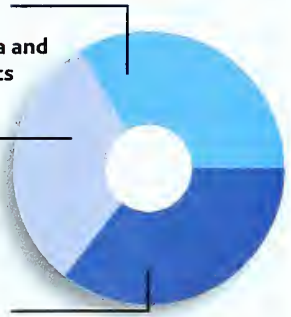
Market Insight: Pet health

The retail pet health market has grown by over 86 per cent since 2005 and is now worth over £106 million. Flea/tick and worming treatments dominate the category, with an almost two thirds share between these two sub-categories. There is widespread recognition that the Frontline flea treatment brand and Drontal wormer brand are the market leaders.

Market changes 2009-10

Total market value £106,700,000 ▲ 8.9%

How the sub-categories compare



33.6% **£35.8m Flea and tick treatments**

31.1% **£33.2m Worming treatments**

35.3% **£37.7 Other** (includes skincare, earcare, tear stains, dental care, herbal/homeopathic products)

Source: Euromonitor International, retail value RSP, 2010

The extent to which pharmacists may want to get involved in sales of pet medicines may depend on their interest, experience and the local area. Questions around the local population – such as the number of dog owners in the area and the location of veterinary surgeries – rightly need to be asked before decisions on what to offer in the way of pet health can be made. The role of the pharmacist can range from simply offering worming and flea control products to prescribing and dispensing medicines and vaccines for livestock. ►►

Case studies

CO-OPERATIVE PHARMACY, CHESTER
PAUL KNAPTON

Paul Knapton, Co-operative Pharmacy branch manager in Chester, has been involved at both ends of the spectrum when it comes to pet medicines.

His current store offers the basic ranges for pet owners, but until recently he worked in a store that had a very strong income stream from dispensing medicines to a local vet clinic and Chester Zoo.

"I can see why pharmacists might be put off because it is a whole different ball game but once you get used to the legal restrictions they are not as onerous as they might seem and it is a great way to draw people in to the store," Mr Knapton says.

He advises pharmacists to look at the demographic they are serving in order to work out what level of pet health they might want to offer.

"But there is nothing stopping any pharmacy selling these medicines," he adds, "and you wouldn't dream of travelling far afield for human medicines so why should it be any different for animal products? Also, they don't take up a huge space and the income is considerable."

He also says that, depending on how much you get involved, the work can be very rewarding. He has worked to find dispensing and formulation solutions for animals with phobias and anxieties and more exotic creatures for whom there isn't a specific animal medicine for their problem.

ROWLANDS PHARMACY, HUYTON, LIVERPOOL
JAYNE STANLEY

Jayne Stanley, branch manager at Rowlands Pharmacy in Huyton, Liverpool, has led the way in taking on pet medicines. Her interest stems from an initial desire to do veterinary studies at university before changing to become a pharmacist.

Thanks to a veterinary diploma she is able to combine her two loves in the perfect career and now stocks treatments for cats, dogs, horses, pigeons, rabbits, fish and rodents.

"We have had an animal section since 2006 and it's been a good seller. It is really interesting and I enjoy it more than the human stuff."

Her best sellers are Frontline treatments for fleas and ticks and Drontal Plus for worming but she also does a roaring trade in Skullcap and Valerian – a calming treatment in the form of tablets or drops – especially around events such as bonfire night.

And she provides a range of herbal remedies for cats and dogs, including garlic and fenugreek treatment for arthritis. "We sell Dorwest herbs and they have our branch listed on their website as a stockist so we attract people that way and we also sell books," Ms Stanley explains.

She also says it has been a great way to build up relationships with customers: "The animals are an extension of the customers really, they come in so we can weigh them and we get to know them."

Potential of pet medicines

Eighteen months ago, at its inaugural conference, Sigma Pharmaceuticals launched its pet health arm SigVet. Business development manager Rajiv Shah says that, despite the rule changes in 2005, it is only really in the past couple of years that pharmacists have started to capitalise on the potential of pet medicines.

"The market is still quite fresh for pharmacists so we run a lot of training evenings and we are launching a new catalogue next month. I would say that now is a great time for pharmacists to get involved, and it's important to remember that the pharmacy is far more accessible than the vet."

Sigma stocks a wide range of pet products for pharmacy sale, from Frontline and Drontal treatments through to grooming products, and it is also able to get hold of specific medicines or food on request.

"We also have a sale or return scheme so they can try the product category in their pharmacy without taking on any risk," Mr Shah says. "The flea product category is huge and Frontline and Drontal have the advantage of being products that need to be used continuously – every few months."

Emma Charlesworth, merchandising manager at Numark, points to its data showing that the pet medicines category has indeed shown some OTC growth, with many retailers choosing to allocate shelf space to flea and worming treatments. Their figures also show that Frontline is currently the brand leader and is used in Numark pharmacies as a "beacon brand" to highlight the category.

"Numark has created a pet meds category on the P meds fixture, which is signposted by Frontline to help the customer navigate the section. Although items are available, there is little evidence to suggest that retailers should expand pet medicines ranges beyond cat and dog treatments, unless location or customer base indicates otherwise. The pet meds treatment category is comparatively new and the real growth appears to be contained within flea and worm treatments at this stage."

Her colleague, Mimi Lau, Numark director of professional and training services, adds that pet health is currently an "untapped market" for independent pharmacies.

"Historically, there has been very little support for pharmacy in understanding the changes in regulation and how to maximise this opportunity. Interestingly, the multiples have got behind this more than independents, with Boots and Lloydspharmacy, for instance, having mobile floor displays and other fixtures displaying flea and worm treatment. I think the multiples have been faster to identify the income potential and independents should really take note."

She says improved training opportunities for pharmacists should enable them to take more of an interest in the pet health category. "Marketing is a must, and we need to educate consumers that they can access pet medicines from pharmacy and not only through their traditional supply route of vets and pet shops."

Brand Watch information on DAP and Feliway is available in the full version of this article online at www.chemistanddruggist.co.uk

Seven tips for boosting pet health sales

1. Contact your wholesaler to find out what they stock and what they can offer you.
2. Contact manufacturers for training packs and information materials.
3. Make contact with local vets and offer to refer customers.
4. Publicise your pet health services, such as with posters advertising brand leaders or top tips for good pet health.
5. Speak to customers about their pets and ask what products would be valuable to them.
6. Do market research to find out if there is any opportunity for sales outside dog and cat products.
7. Use the leading brands and products as beacons to direct customers to your pet health range.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on pet health

REFLECT	Do I offer my customers a good pet health service?
PLAN	Consider how an increased pet health offering could benefit my customers
ACT	Implement tips in this article to improve my pet health offering
EVALUATE	Do my customers get a better pet health service in my pharmacy?

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Career ladder

...at the GPhC

The General Pharmaceutical Council (GPhC) has announced the appointment of Hugh Simpson as director of policy and communications.

Currently deputy director of communications at the NHS Confederation, Mr Simpson will join the future regulator as a member of the executive team in September and report to chief executive and registrar Duncan Rudkin.

...at APTUK

Former vice-president of the Association of Pharmacy Technicians UK (APTUK) Steve Acres was elected president at the organisation's annual conference last month. "Pharmacy technicians are playing an increasingly important role in both the development and delivery of pharmacy services," Mr Acres said.

"These are challenging but exciting times and I will do my utmost to steer APTUK toward growth and the delivery of excellent and sustainable professional leadership for our members."

...at the MHRA

The independent Appointments Commission has appointed a school of pharmacy professor to the MHRA's Herbal Medicines Advisory Committee.

Simon Gibbons, professor of phytochemistry at the School of Pharmacy, University of London, is appointed to the unpaid position until the end of 2013.

...at the ABPI

The Association of the British Pharmaceutical Industry (ABPI) has appointed marketing expert Carol Blount as the new head of commercial affairs.

Ms Blount joins the association with over 15 years' senior leadership experience in the pharmaceutical industry, most recently as AstraZeneca head of innovation.

She will be responsible for all ABPI commercial affairs, including NHS joint working and QIPP (quality, innovation, prevention and productivity) initiatives, and commercial aspects of PPRS, supply chain and distribution initiatives.

Got a burning careers question?
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CAREERS

Talking to the media

Health experts are in demand by the media, and pharmacists can use this to boost their skills, finds **Chris Chapman**

It seems health is always in the news. Whether it's about the ethics of supplying contraceptives, medicines supply problems or advice on the latest over the counter medicines, today's media juggernaut of 24-hour news is always eager for pharmacists to share their expert opinion. And it's not just a relationship that benefits journalists, either. Talking to the press can give a real boost to your own career.

Raj Patel, of Mount Elgon Pharmacy in London, says speaking to the press is something that has always interested him. However, it was only when he started engaging that he realised the difference it could make to his business.

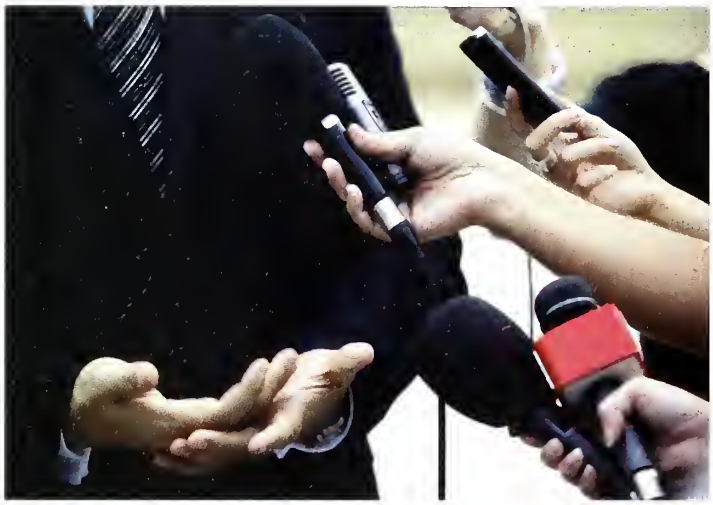
"It does help business," he says. "Patients know what you can do, and people have confidence in you. We have people that don't live near, but they visit the pharmacy for blood pressure checks. It builds a good rapport with customers."

Mr Patel said he first contacted the press to celebrate his pharmacy's first anniversary, to thank his customers. "From there it's just cascaded," he says. "I've had media contact me from magazines, GMTV, the BBC – there are always stories and they want a pharmacist's perspective."

Weldricks area support pharmacist Ravi Mohan says he has had a similar experience. Since he was asked to do an 'expert's corner' session for BBC Radio Sheffield he has found himself regularly approached by the media.

"If there is comment needed locally or nationally, Radio Sheffield have my number," Mr Mohan says. "I'll either go in, or give an interview. It means community pharmacy has a voice locally in Sheffield."

Mr Mohan says talking to the media has also boosted his communication skills. "I feel more confident in speaking to different people," he says. "I've just taken on the role of chair of my LPC. I can't say that's directly from speaking to the media, but it's given me extra confidence. I've done a few talks to patient groups, too... it's not directly media-based, but it branches off."



Talking to the press is a great way to raise the profile of your pharmacy

For employee pharmacists who want to take the plunge and speak to the media, the best place to start is often head office. Larger companies will usually issue press releases through their communications teams and appoint media spokespeople, who usually go through media training.

Mr Mohan, who did a media training course with the NPA, says the day's training was a real boost to his skills. "There were three trainers," he says, "one on radio, one on TV, and one on newspapers. They recorded our sessions and gave us feedback, for example how to avoid getting drawn into debates and sticking to the subject, and getting your points across."

Pharmacists who have undergone their media training are able to raise the profile of their profession and respond to stories, even if it's a negative one, says NPA spokesperson Mark Beckett. Pharmacists who have undergone media training from the pharmacy body have appeared on TV and radio, and participated in the NPA's Ask Your Pharmacist week launch at the Houses of Parliament. The NPA can also provide briefing notes on hot topics, and even questions and answers that pharmacists can use for newspaper columns, Mr Beckett adds.

However, before you embark on your career in the media, a word of caution: the need to keep stories relevant means that journalists usually have tight deadlines to meet, and requests will often have a tight turnaround.

"If you're going to be a media person you have to be available at 24 hours' notice," Raj Patel says. "But it's great fun – a break from the norm. It adds a bit of spice to the day. I love it."

The NPA has places available for a free media training day on September 26 in Manchester. For more information contact Mark Beckett on m.beckett@npa.co.uk or 01727 858687 ext. 3529.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on media skills

REFLECT	Could I help boost pharmacy's public profile?
PLAN	Contact head office about becoming a media spokesperson.
ACT	Attend any media training available and offer local media outlets interviews, comments and articles.
EVALUATE	Have I helped to raise the sector's profile locally?

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in partnership with C+D Training

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Springboard is a pre-registration programme offered by Medway School of Pharmacy in partnership with C+D. Springboard equips pre-registration students with the skills and confidence to ensure a smooth transition from pharmacy graduate to practicing pharmacist.

The Springboard pre-registration training programme consists of eight study days facilitated and delivered by staff from C+D and Medway School of Pharmacy covering a wide variety of topics, enabling students to meet the appropriate competencies in the RPSGB's student handbook.

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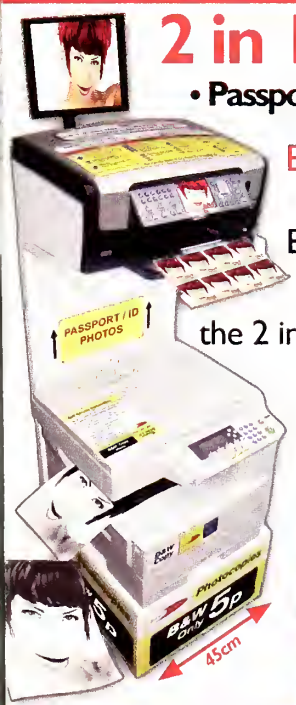

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Postscript...

Midlands-based Murrays Healthcare opened its doors 90 years ago. Last month the family-run group held a celebration to mark the anniversary

Murrays celebrates 90 years of service

Originally from the Black Country in England, Murrays went back to its roots and hired the Black Country Museum for the celebrations (above). Employees and their families were invited to the event, which ended in a firework display. Here, we mark some important milestones for the group.

1920

Cyril Murray (right) opened his first pharmacy in Tipton, West Midlands, on September 29. Cyril had originally been a pharmacist on a hospital train, which picked up casualties across northern France during the First World War.

1950

A second pharmacy was opened in a wooden shed at Tividale. This remained open until 1971, when it was closed due to redevelopment of the area.

1958

Clive Murray qualified as a pharmacist and entered the business.

1977

The group took over AB Cope Pharmacy at Princes End.

1978

Expansion began in earnest, with the opening of two new pharmacies, and continued at a rapid rate with the acquisition of three more.

1990

Current owners Duncan Murray and Fionna Murray entered the business full time.

1995

The company acquired the 103-year-old pharmacy of Alfred Yeates in Stourbridge.

2006

The company installed its first dispensing robot. Five more followed over the next couple of years.

2007

The 25th pharmacy was acquired by the group.

2010

The company celebrates its 90th birthday.

Each year the company gets through:

- One million paper bags
- Two million paracetamol tablets

Is your pharmacy celebrating a milestone this year? Let Postscript know what you're up to:
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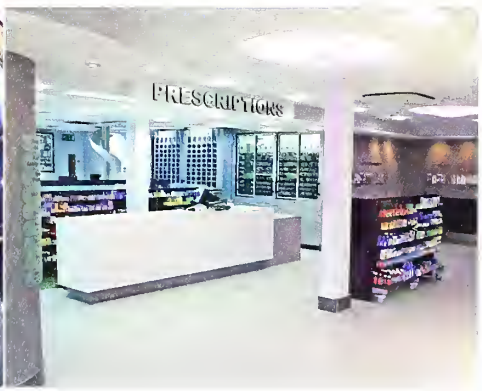

Murrays' Stourbridge store, and inside the company's C+D Platinum Design Award-winning Malvern store

A word from the director

"Murrays will continue to expand, either by relocation or the purchase of new pharmacies as and when they become available," says Murrays' director Fionna Murray (above).

"We are constantly looking at new technology within pharmacy in order to increase efficiency and provide a better working environment for our employees.

"Growth within the existing pharmacies has been achieved by the relocation of 10 pharmacies into health centres over the past 10 years.

"Our successes include 12 C+D Platinum Design Awards for our unique designs over the years.

"We currently employ 250 staff, and have a successful wholesale mobility company, Z-tec, whose stock is mainly purchased from China and made to our specifications.

"Murrays has been a trendsetter within pharmacy, but very much retained a family spirit. This will continue!"

Congratulations to Jon Martin of Brynamman Pharmacy, Carmarthenshire, who correctly spotted the C+D mug in our June 19 issue (p25, middle photo, lady in the red dress). The mug is on its way to you!

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HP 0358. Date of preparation: May 2010.